3. Robins, E., E. H. Schmidt, and P. O'Neal, "Some Interrelations of Social Factors and Clinical Diagnosis in Attempted Suicide." A Study of One Hundred-Nine Patients, *Am. J. Psychiat.,* in press.
4. Batchelor, I. R. C., and M. B. Napier, "The Sequelae and Short-Term Prognosis of Attempted Suicide." The Results of a One-Year Follow-Up Study of 200 Cases, *J. Neurol., Neurosurg. and Psychiat.,* 17: 261-266 (1954).
5. Sainsbury, P., "Suicide in London. An Ecological Study," *Maudsley Monographs, No. 1,* Chapman & Hall, Ltd., London, 1955.
6. Shneidman, E. S., and N. L. Farberow, "Clues to Suicide," *Public Health Rep.,* 71:109-114 (1956).
7. Jameison, G. R., "Suicide and Mental Disease." A Clinical Analysis of One Hundred Cases, *Arch. Neurol. & Psychiat.,* 36: 1-12 (1936).
8. Rose, A. M., and H. R. Stub, "Summary of Studies on the Incidence of Mental Disorders," in *Mental Health and Mental Disorder: A Sociological Approach,* ed. A. M. Rose. W. W. Norton & Co., New York, 87-116, 1955.
9. Rosanoff, A. J., L. M. Handy, and I. R. Plesset, "The Etiology of Manic Depressive Syndromes with Special Reference to Their Occurrence in Twins," *Am. J. Psychiat.,* 91, 725-762 (1935).
10. ————, and S. Brush, "The Etiology of So-Called Schizophrenic Psychoses with Special Reference to Their Occurrence in Twins," *Am. J. Psychiat.,* 91, 247-286 (1934).
11. Kallmann, F. J., "The Genetics of Psychoses. An Analysis of 1,232 Twin Index Families," *Am. J. Human Genetics,* 2, 385-390 (1950).
12. ————, "The Genetic Theory of Schizophrenia. An Analysis of 691 Schizophrenic Twin Index Families," *Am. J. Psychiat.,* 103, 309-322 (1946).
13. Verschuer, O. v., "Twin Research from the Time of Sir Frances Galton to the Present Day," *Proc. Royal Soc. Med., Series B,* 128, 62-81 (1939).
14. Lindquist, G., "Prognosis and Course in Manic-Depressive Psychoses. A Follow-Up Study of 319 First Admissions," *Acta psychiat et neurol.,* Suppl. 35, 1-96 (1945).
15. Wheeler, E. O., P. D. White, E. W. Reed, and M. E. Cohen, "Neurocirculatory Asthenia (Anxiety Neurosis, Effort Syndrome, Neurasthenia): A Twenty-Year Follow-Up Study of 173 Patients," *J.A.M.A.,* 142, 878-889 (1950).
16. Holt, W. L., Jr., and W. M. Holt, "Long-Term Prognosis in Mental Illness. A Thirty-Year Follow-Up of 141 Mental Patients," *Am. J. Psychiat.,* 108, 735-739 (1952).
17. Kraepelin, E., *Dementia Praecox and Paraphrenia,* trans. by R. M. Barclay. Edinburgh, E. & S. Livingstone, 1919.
18. Bond, E. D., "Results of Psychiatric Treatment with a Control Series. I. Schizophrenia," *Am. J. Psychiat.,* 110:561-566 (1954). "IV. General Data and Summary," *Am. J. Psychiat.,* 110:885-887 (1954).
19. Bond., E. D., and H. H. Morris, Jr., "Results of Psychiatric Treatment with a Control Series. III. Manic-Depressive Reactions," *Am. J. Psychiat.,* 110, 883-885 (1954).
20. Guze, S. B., "Theory and Observation in Psychiatric Research," See p. 4 this issue.

Mental Illness and the Runaway: A 30-Year Follow-Up Study

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Introduction

The effect the mental health movement has had on our attitudes toward the juvenile delinquent might be summarized as a change from the goal of Gilbert and Sullivan's *Mikado* of making "the punishment fit the crime" to the goal of making "the punishment fit the criminal." We aim not at retribution for the crime against society, but at some sort of therapy precisely tailored to the needs of the particular culprit which will so change him that he no longer desires to act in an anti-social fashion.

So ambitious a goal requires a complex fund of knowledge about the causes of anti-social behavior, if we are interested in the prevention of juvenile delinquency, and about therapies which may hope to alter established problem behavior. The years since the mental hygiene movement has brought these changes in our attitudes have seen a growing body of research into both causes of juvenile delinquency and methods of treatment. Research into the causes of delinquency has shown that poverty,[1] criminal associations,[2] separation from parents,[3] living in racially mixed and rooming house neighborhoods,[4] poor interpersonal family relations and certain personality traits[5] distinguish offenders from non-offenders and recidivist offenders from non-recidivist offenders. Research in therapy has produced less in terms of substantial correlations, probably because the follow-up studies necessary to evaluate therapy are more expensive and time-consuming than record research or retrospective evaluation of the early history of incarcerated delinquents. The few evaluations of therapy that have been attempted have been discouraging.[6]

Although the growing fund of information about juvenile delinquency is impressive, and the number of variables found to correlate with delinquency are many, there is a striking absence of research into psychiatric disease as a possible factor in the genesis of delinquency, the careers of delinquents, and their susceptibility to various therapies. There are several hints in findings available which suggest that psychiatric disease may be an important factor in delinquency. The Gluecks,[7] for instance, report differences in the Rohrschach findings in delinquent and non-delinquent boys, and also differences in personality variables as perceived in psychiatric interview.

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1. Clifford R. Shaw and Henry D. McKay, *Juvenile Delinquency and Urban Areas,* Chicago, University of Chicago Press, 1942; Albert J. Reiss, "The Accuracy, Efficiency, and Validity of a Prediction Instrument," *Am. J. of Soc.,* 56, 552-561 (May, 1951); and H. Ashley Weeks, "Predicting Juvenile Delinquency," *Am. Soc. Rev.,* 8, 40-46 (February, 1943).
2. Edwin H. Sutherland and D. R. Cressey, *Principles of Criminology,* 5th ed., Philadelphia, Lippincott, 1955.
3. Douglas A. Thom and Florence S. Johnston, "Time as a Factor in the Solution of Delinquency," *Mental Hygiene,* 25, 269-287 (April, 1941).
4. Bernard Lander, *Towards an Understanding of Juvenile Delinquency,* New York, Columbia Univ. Press, 1954.
5. Sheldon and Eleanor T. Glueck, *Unraveling Juvenile Delinquency,* New York, Commonwealth Fund, 1950.
6. Edwin Powers and Helen Witmer, *An Experiment in the Prevention of Delinquency: the Cambridge-Somerville Youth Study,* New York, Columbia University Press, 1951.
7. Sheldon and Eleanor T. Glueck, *op. cit.,* pp. 215-252.

Hathaway and Monachesi[8] report differences in MMPI scores between delinquents and non-delinquents and between delinquents who were successful on parole and those who were not. Bronner[9] reports that children with "mental or personality abnormality" had unfavorable careers despite treatment at the Judge Baker Clinic. None of these studies, however, attempts to make a psychiatric diagnosis of the delinquent child. The McCords[10] report differences in therapeutic success with children having various psychiatric diagnoses, but their cases in any particular diagnostic group are few, and their measures of success are psychological test scores rather than any objective measure of adjustment to the outside world.

Apart from the suggestions found in the research of others, there are ample reasons for supposing that psychiatric disease must play an important role in determining whether a delinquent will become a recidivist, and whether he will respond to therapy. The disease, sociopathic personality,[11] for instance, which is most frequently observed as a disease of young adulthood, is characterized by a propensity for becoming involved in conflicts with the law, particularly through belligerency, thefts, excessive alcohol intake, vagrancy, and irresponsibility toward spouse and children. If the juvenile delinquent is a young sociopath, obviously his chances of being a recidivist should be very high. The sociopathic personality, as well as individuals with other psychiatric diseases, particularly alcoholism and schizophrenia, has a very poor prognosis in therapy when adult. Treatment by drugs, shock, psychoanalysis, and psychotherapy have all been singularly unsuccessful with these psychiatric categories. If the juvenile delinquents who are subjected either to traditional reformatory experience, to mental hospitalization, or to the new milieu therapies are children who are showing early symptoms of these treatment-resistant diseases, it should probably be expected that the therapy will fail. If therapies are compared without controlling the rate of representation of these various psychiatric diseases, apparent differences in the success of diverse therapeutic methods may actually be differences in the proportion of patients whose psychiatric diseases are largely untreatable by present methods. The reformatory, for instance, which has been called "a training school in crime," may turn out a high rate of children who go on to become adult criminals[12] not because the reformatory's punitiveness engenders crime but because a high proportion of young sociopaths are selected for the reformatory by the fact that they are too difficult to handle in any other setting.[13]

The Study[14]

To point to the need for investigating the relation of psychiatric diagnosis to juvenile delinquency is not to imply that this is a simple task that has somehow been overlooked. Making a psychiatric diagnosis in children is intrinsically a difficult technical problem, aspects of which are still unsolved. The difficulties involved result from the special characteristics of psychiatric diseases. Since relatively few psychiatric diseases are accompanied by physical signs, they cannot be diagnosed by laboratory tests or physical examination. Since, in addition, specific etiological factors are rarely known, the occurrence of any particular experience, kind of life situation, or the presence of hereditary factors cannot be used to prove the presence of a particular disease. In most cases, the sole diagnostic tools are the symptoms of the patient and a knowledge of the course of the illness. In children, the diagnosis has to be formulated on the basis of a partially developed syndrome, in which the symptoms may be incompletely exhibited and the typical course of the disease has not yet shown itself. Because of these difficulties, there have so far been few descriptive studies of the psychiatric diseases of children. Consequently, even the diagnostic criteria available have been less carefully worked out for children than for adults.

In the present paper, an approach will be taken which circumvents some of the methodological difficulties inherent in making psychiatric diagnoses in children with anti-social behavior problems. Since psychiatric diagnoses can be better made in adults than in children, children with anti-social behavior will be followed into adulthood and then diagnosed after the full pattern of their psychiatric diseases has had time to unfold. Making a diagnosis in adults who had a history of childhood behavior problems is by no means a completely satisfactory solution to the problems of diagnosing children. For instance, the relation of the diagnosis to recidivism cannot be studied. Since the presence or absence of adult criminality is a factor in making the diagnosis, using

8. Starke R. Hathaway and Elio D. Monachesi, *Analyzing and Predicting Juvenile Delinquency with the MMPI,* Minneapolis, Univ. of Minnesota Press, 1953.

9. Augusta F. Bronner, "Treatment and What Happened Afterward," *Am. J. of Orthopsychiatry,* 14, 28-35 (Jan., 1944).

10. William and Joan McCord, *Psychopathy and Delinquency,* New York, Grune & Stratton, 1956.

11. For the official definition of this syndrome, see the *Diagnostic and Statistical Manual: Mental Disorders,* Washington, D.C., American Psychiatric Assoc., pp. 38-39, 1952. The precise criteria for making a diagnosis of sociopathic personality (under the older nomenclature, "psychopathic personality" or "constitutional psychopathic inferior") have been long subject to argument among psychiatrists. The argument revolves around the extent to which objective social adjustments or underlying personality traits such as guiltlessness, impulsivity, inability to inhibit short-term in favor of long-term goals, inability to form deep personal attachments, and aggressivity should form the core of the diagnostic criteria. There is essential agreement, however, that the sociopathic personality fails to meet the demands of society in most areas of his life.

12. Alida C. Bowler and Ruth S. Bloodgood, *Institutional Treatment of Delinquent Boys,* Nos. 228 and 230, Washington, U.S. Children's Bureau Publications, Government Printing Office, 1936; Sheldon and Eleanor T. Glueck, *Five Hundred Criminal Careers,* New York, Knopf, 1930.

13. It may well be that both selective factors in the population and inadequate therapeutic techniques are operating to create the high rate of recidivism among reformatory graduates.

14. The decision to limit the present paper to *male* runaways was made in the interest of simplicity of presentation after it was found that male runaways differed so much from female runaways in respect to the original motivation for running away, the way the running away was handled, and adult psychiatric diagnosis that male and female runaways could not be treated as a homogeneous group. Another paper, to be published shortly, contrasts the male and female runaways. The runaway girls consist of 24 cases, 35% of the female patients so far interviewed.

the diagnosis to explain criminality would be to argue circularly. Making a diagnosis in adults is, nevertheless, useful, since it permits searching descriptions of the childhood problems for uniformities within diagnostic categories, uniformities which may become criteria for recognizing the psychiatric syndromes in their early stages. When such criteria become available, psychiatric diagnosis in childhood can be used as a predictor of delinquency, of recidivism, and of amenability to therapy. As a result, a more discriminating application of therapeutic techniques should be possible, with a consequent higher rate of therapeutic success.

In this paper, the adult psychiatric status of male patients who were runaways as children will be investigated and compared with the adult psychiatric status of male patients with other kinds of childhood behavior problems and with that of normal male control subjects. "Running away" was chosen as the behavior problem to study because it promised to select a group with a serious degree of anti-social behavior in childhood. Nye and Short, in developing their delinquency scale,[15] found that "running away" was the problem which formed the cutting point for separating a population of high school boys from a training school population. It was the first item on their delinquency scale which did not occur in at least 10% of the high school sample. It did, however, occur in 61% of the training school sample. Therefore, "running away" appeared to be a childhood behavior problem highly related to serious delinquent behavior in boys.

At the present time, the author, in cooperation with a psychiatrist, is engaged in a follow-up study of a consecutive series of patients seen at a child guidance clinic between the years 1924 and 1929. The patients are being located and interviewed approximately 30 years after their initial referral to the clinic. Part of the standardized interview is a careful review of psychiatric history and symptomatology, which in most cases permits a specific psychiatric diagnosis to be made by the psychiatrist or permits the diagnosis of "psychiatrically normal." Included as subjects are all those patients referred within the years specified who had an I.Q. of 80 or better (by Stanford-Binet), were of Caucasian race, and were under age 18 at the time of referral. There are 524 such patients, of whom 380 are male. At the present time, 179 male patients have been interviewed. In addition, a group of 100 control subjects (70 of whom are male), selected from the records of the St. Louis public schools, matched with the patient subjects for age, sex, I.Q., race, and neighborhood, are also being interviewed and a psychiatric diagnosis made in the same manner. At the present time, 46 male control subjects have been interviewed. For purposes of this paper, all interviewed male patients whose clinic record mentioned running away from home (defined as staying away without permission at least over night) will be studied in terms of their current diagnosis and compared with male control subjects and with male patients who did not have the problem of running away. It will be pointed out that the way in which their running away was handled by the courts shows some relation to their adult diagnosis. A review of the description of their runaway escapades will suggest that there may be certain signs in childhood useful in predicting future psychiatric diagnosis.

15. F. Ivan Nye and James F. Short, Jr., "Scaling Delinquent Behavior," *Am. Soc. Rev.*, 22, 326-331 (June, 1957).

Results

Among the 179 male patients interviewed, 56 (31%) had a history of running away from home. Since Nye and Short found running away a rare phenomenon among high school students, but frequent among training school boys, we expected that runaways would have a high rate of delinquency. In our group, 75% had appeared before a juvenile court; 45% had been to a reformatory.

The runaway boys turned out to have a high rate of psychiatric illness as adults, compared both with the normal control subjects and with male patients who did not run away as children (Table 1). Since, however, the runaways were known to have a higher incidence of delinquency than other patients or control subjects, the question arises as to whether their high rate of psychiatric disease is related to their particular behavior problem—running away—or only to their high rate of delinquency. Among both runaways and non-runaways, delinquency and reformatory experience were found to be highly correlated with adult psychiatric illness (Table 2). Although the high rate of psychiatric disease in

Table 1
Psychiatric Diagnosis

	Runaways	Other Patients	Control Subjects
No Disease	14%*	43%*	63%
Sociopathic Personality	32 +	11 +	--
Psychosis	16	14	2
Neurotic	11	14	15
Alcoholic	7	2	--
Undiagnosed	20	16	20
	100%	100%	100%
	N = 56	N = 123	N = 46

* χ^2 of difference between these two figures = 14.0, $p < .001$.

+ χ^2 of difference between these two figures = 14.1, $p < .001$.

Table 2
Relation of Patients' Juvenile Offense to Psychiatric Diagnosis

	Reformatory		Delinquent, but no Reformatory		Non-delinquent	
	Runaway	Non-Runaway	Runaway	Non-Runaway	Runaway	Non-Runaway
No Disease	4%	23%	18%*	48%*	36%	46%
Sociopathic Personality	56	46	18	8	7	5
Psychosis	16	8	24	16	7	13
Neurotic	4	8	12	4	21	19
Alcoholic	4	--	6	4	7	1
Undiagnosed	16	15	23	20	22	16
	100%	100%	100%	100%	100%	100%
	N = 25	N = 13	N = 17	N = 25	N = 14	N = 85

* χ^2 of difference between these two figures = 4.05, $p < .05$; for total delinquents, $\chi^2 = 9.13$, $p < .01$.

runaways can, therefore, be largely accounted for by their higher rate of delinquency and reformatory experience, runaways exceeded non-runaways in their rate of psychiatric disease within each category of juvenile offenses. Running away appears to be predictive of later psychiatric disease even when the high rate of delinquency and reformatory experience among runaways is taken into account.

A single diagnostic category, "sociopathic personality," accounts for the difference in the rate of psychiatric disease between the runaway males and other male patients. This disease occurs much more frequently in reformatory graduates than in the remainder of the patients, among both runaways and non-runaways.

Kanner,[16] in describing the psychiatric diseases of runaways, includes psychopathic (sociopathic) personality, schizophrenia, epilepsy, paresis, mental deficiency, and hysteria. He seems to feel, however, that a large proportion of runaway children have no psychiatric disease. In limiting our patient group to those with an I.Q. of 80 or over, we have eliminated the mental deficients. The runaways in our study fell into all other diagnostic categories he mentioned, with the exception of epilepsy. However, our rate of runaways without psychiatric disease was small. It is possible that runaways referred to a child guidance clinic have a higher rate of psychiatric disease than would be found in a total population of runaways.

A review of the ways in which the boys who ran away were handled shows that the running away of 23% was never reported to the police (Table 3). Thirty-one percent had the episode reported to the police, but were never prosecuted. In most of these cases, the boy was merely reported missing and never had any direct contact with the police. Forty-six percent of the runaway boys were seen in juvenile court on charges of running away or incorrigibility. This includes 9% who were put on probation only, 5% sent to foster homes, 5% sent to mental hospitals, and 27% sent to reformatories.[17]

Table 3

How Running Away Handled
vs. Diagnostic Groups

	No Disease	Sociopath	Psychotic	Neurotic	Alcoholic	Un-diagnosed	Total
No Prosecution	87%*	41%*	44%	50%	50%	58%	54%
No police report	25%	12%	22%	17%	25%	41%	23%
Reported only	62	29	22	33	25	17	31
Prosecuted	13	59	56	50	50	42	46
Probation	--	6	22	--	--	17	9
Placement	--	6	22	33	25	--	11
Reformatory	13	47	12	17	25	25	27
	100%	100%	100%	100%	100%	100%	100%
	N = 8	N = 17	N = 9	N = 6	N = 4	N = 12	N = 56

* χ^2 (using the Yates correction) of the difference between these two figures = 4.24, $p < .05$.

When the way the running away was handled is related to the psychiatric diagnosis, it is found that those diagnosed "no disease" had the lowest rate of prosecution for their running away, and the sociopaths had the highest rate of prosecution. Since the diagnosis was made long after the running away occurred, the question cannot be answered as to whether the psychiatric illness or the method of handling came first. If the psychiatric illness came first, psychiatrically ill runaways may have received more official attention because they appeared more disturbed. If the method of handling came first, undergoing reformatory or other deleterious treatment may have been a factor in the development of the psychiatric disease. This question is complicated by the fact that the runaways had a high rate of delinquencies for other offenses, as well as for running away. Of those whose running away was not reported to the police, or not prosecuted if reported, 60% were prosecuted for other crimes, chiefly larceny, and 23% served reformatory sentences for other crimes. Therefore, even those whose running away had little official attention had considerable exposure to the courts on other counts.

An interesting finding about the relation of psychiatric diagnosis to the court handling of these children is the high rate of reformatory experience among children who were diagnosed psychotic as adults. Of the nine so diagnosed four had been in a reformatory, one as a runaway and three for larceny. More of the young psychotics went to a reformatory than went to a mental hospital, and two went both to a reformatory and a mental hospital. Their high rate of reformatory experience probably resulted from their inability to make a successful adjustment to any of the prior arrangements tried for them and from the fact that they did not then show a pattern of symptoms that permitted a diagnosis of childhood psychosis, a diagnosis that would have suggested institutionalization in a hospital rather than in a reformatory. The two who went both to a reformatory and a hospital were sent first to the reformatory. Their psychosis was not recognized in their early adolescence.

The disposition of the runaway turned out to be roughly related to later diagnosis, with sociopaths ending in reformatories, psychotics ending either in a mental hospital or reformatory, and normal and neurotic patients receiving little official attention. The difference in handling these groups probably did not reflect any perception of them as different by the officers in charge, but rather resulted from a sifting process, in which first offenses are treated leniently and punishment becomes more stringent as the offenses become more flagrant. The failure of the sociopaths to respond to warning, probation, or placement probably accounts for so many of them ending in the reformatory. Failure to learn by experience is considered one of the characteristic features of

16. Leo Kanner, *Child Psychiatry,* Springfield, Illinois, Charles C. Thomas, 1942, p. 394f., and 1957, p. 720.

17. These categories refer to the *final* disposition of the runaway. In most cases more severe treatment was preceded by all or most of the hierarchy of less severe treatments. Before being termed a juvenile delinquent, boys had been reported missing and returned home one or more times. Before being incarcerated, juvenile delinquents had been tried on probation or in foster home placement and failed.

this psychiatric syndrome. We may ask, however, whether it might have been possible to predict the psychiatric outcome of these children at the time of their running away, before they were tried in various kinds of punitive or therapeutic situations.

A survey of the descriptions of the episodes of running away yields some interesting suggestions about differences, although there are too few cases within each diagnostic group and too much variety in the motivation of the running away to permit statistical treatment.

Among the children later diagnosed "sociopathic personalities," the running away in several cases seemed a response to a desire for a spree or adventure. The children went with friends on trips or to the home of a doting relative or to hang around army camps. In other cases, the running away was a protest against restrictions of their freedom at home. These children ran away because they did not wish to contribute any of their wages to the family income, or because the family would not permit their keeping late hours. Others responded to criticism and punishment by running away. In only one case among the sociopaths, did the boy run away to avoid threatened punishment. The running away was rather a protest over treatment already administered. In two cases, when asked for reasons for running away, the boys told stories of fantastic parental neglect and abuse, stories apparently not based on fact.

In those children later diagnosed as psychotic, the running away seemed neither a protest nor a spree. In several cases, it appeared curiously unrelated to any external events. The child apparently wandered off without reason or destination and continued wandering until returned by the police. In one of the psychotic children, this pattern continued for many years with 15 to 20 arrests before the child was finally hospitalized. In other cases, the psychotic child seemed to be responding to external events, but to events that would not be expected to create so dramatic a reaction; e.g., one ran away because there was talk about germs at home, another because his mother asked him to bring in coal.

Among those children who turned out to be psychiatrically normal as adults, the chief reasons for running away seemed to be to escape punishment or to return to his parents from a foster home. In one case, the child ran away to play with some friends of bad reputation whose company had been forbidden him.

Discussion

A follow-up study of boys who were runaways is presented as an illustration of the ways in which a psychiatric diagnosis made 30 years after these children were seen in a child guidance clinic can be used in lieu of adequate psychiatric diagnosis in childhood. It also suggests ways in which adult diagnosis can retrospectively suggest criteria for improving diagnosis in childhood.

Running away was found to occur largely among juvenile delinquents, and particularly among those who end in a reformatory. Runaways were found to have a high rate of psychiatric disease as adults compared with other child guidance clinic patients and with normal boys. Boys in whom running away is a problem, particularly those who also have other delinquencies, such as larceny, who run away for the sake of adventure or out of resentment of treatment at home, and who end in a reformatory, were found to have a high probability of fitting the diagnosis of sociopathic personality as adults. Unanswered at this point is the question as to whether the reformatory experience is a factor in initiating their psychiatric disease or whether the reformatory simply receives a high proportion of the boys with this disease. Since the act of running away, which predates entrance into the reformatory, appears to follow different patterns for the various diagnostic groups, it seems probable, however, that the psychiatric disease, or a predisposition to that disease, predated the method of handling.

The high rate of boys diagnosed "sociopathic personality" in the reformatory group appears consistent with the personality findings of the Gluecks and of Hathaway and Monachesi. Both used reformatory samples, in whom the Gluecks found a high incidence of defiance, adventurousness, destructiveness, and social assertion and in whom Hathaway and Monachesi found high scores on the "Psychopathic Deviant" scale of the MMPI.

Since children with different psychiatric diagnoses as adults were, in fact, handled in different ways by the authorities, our supposition that the psychiatric diagnoses are by no means randomly distributed among populations experiencing various therapeutic programs is supported. Reformatories probably still receive a disproportionate share of sociopathic and psychotic children. This finding reaffirms our conviction that different techniques of therapy with delinquents cannot be adequately compared without controlling the psychiatric populations they are called upon to treat.